

Welcome to the Del Valle Dental Plan

The Del Valle Dental Plan is a reduced fee dental program administered by Valley Dental Care, PC. This plan offers a cost-effective alternative to traditional dental insurance by providing quality dental care at reasonable and affordable prices. **Del Valle provides for substantially reduced fees on most dental procedures (as much as 20% - 60% off usual and customary fees).** There are no limits on visits or the amount of dental care you receive per year. Our belief is that proper preventive and comprehensive dental care provided regularly, at affordable prices, will assure that you and your family have the healthiest and happiest smiles possible.

WHAT ARE THE BENEFITS?

- Reduced fees for all dental services
- No waiting periods
- No claim forms
- No deductibles
- Pre-existing conditions are covered
- No limits on visits or amount of dental care

Del Valle Yearly Cost

Annual

| | |
|----------------------|-------|
| Member | \$72 |
| Member + 1 Dependent | \$108 |
| Family | \$144 |

Is the Del Valle Plan Insurance?

The Del Valle Dental Plan is not insurance; it is a reduced fee plan. It is a reasonable, cost-effective alternative to insurance and may be used when traditional insurance has elapsed.

Who is eligible to join?

Everyone is eligible to participate in the Del Valle Plan. Individuals of any age and their spouses are eligible. Under the Family Plan, unmarried dependents who are full time students, are eligible to age 26.

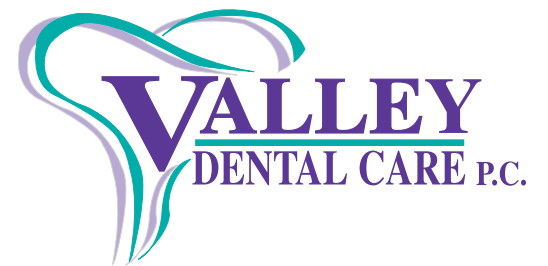
How soon will coverage begin?

As soon as we receive your enrollment application and membership fee, coverage will begin. The plan will expire one year from that date.

Coordination of Benefits

The Del Valle Plan is not dental insurance and is not designed to coordinate with any other dental coverage; however, the Del Valle Plan can be used after all your other dental benefits have been exhausted.

THE DEL VALLE PLAN



1300 N. McClintock Dr.
Suite E-12
Chandler, AZ 85226
480-897-2483
www.valleydentalcare.com

Welcome to the Del Valle Dental Plan

The Del Valle Dental Plan is a reduced fee dental program administered by Valley Dental Care, PC. This plan offers a cost-effective alternative to traditional dental insurance by providing quality dental care at reasonable and affordable prices. **Del Valle provides for substantially reduced fees on most dental procedures (as much as 20% - 60% off usual and customary fees).** There are no limits on visits or the amount of dental care you receive per year. Our belief is that proper preventive and comprehensive dental care provided regularly, at affordable prices, will assure that you and your family have the healthiest and happiest smiles possible.

WHAT ARE THE BENEFITS?

- Reduced fees for all dental services
- No waiting periods
- No claim forms
- No deductibles
- Pre-existing conditions are covered
- No limits on visits or amount of dental care

Del Valle Yearly Cost

Annual

| | |
|----------------------|-------|
| Member | \$72 |
| Member + 1 Dependent | \$108 |
| Family | \$144 |

Is the Del Valle Plan Insurance?

The Del Valle Dental Plan is not insurance; it is a reduced fee plan. It is a reasonable, cost-effective alternative to insurance and may be used when traditional insurance has elapsed.

Who is eligible to join?

Everyone is eligible to participate in the Del Valle Plan. Individuals of any age and their spouses are eligible. Under the Family Plan, unmarried dependents who are full time students, are eligible to age 26.

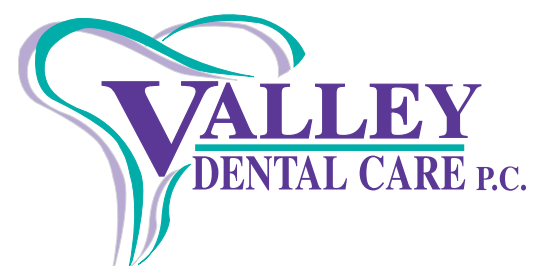
How soon will coverage begin?

As soon as we receive your enrollment application and membership fee, coverage will begin. The plan will expire one year from that date.

Coordination of Benefits

The Del Valle Plan is not dental insurance and is not designed to coordinate with any other dental coverage; however, the Del Valle Plan can be used after all your other dental benefits have been exhausted.

THE DEL VALLE PLAN



1300 N. McClintock Dr.
Suite E-12
Chandler, AZ 85226
480-897-2483
www.valleydentalcare.com

THE DEL VALLE PLAN

| Code | Description | Fee | Code | Description | Fee | Code | Description | Fee |
|-------------------------------|--|-------|------|---|-------|-------------------------------|--|-------|
| Diagnostic | | | | | | | | |
| 0120 | Exam, periodic | \$24 | 3220 | Therapeutic pulpotomy | \$76 | 7111 | Extraction-coronal remnants, prim | \$124 |
| 0140 | Exam, problem focused | \$33 | 3221 | Pulp debridement/not done as part of RCT | \$80 | 7140 | Extraction-erupted tooth | \$140 |
| 0150 | Exam, comp, new or established patient | \$25 | 3310 | Root canal therapy-anterior | \$556 | 7210 | Extraction-erupted tooth surgical | \$212 |
| 0180 | Exam, periodontal, including charting | \$50 | 3320 | Root canal therapy-bicuspid | \$648 | 7220 | Extraction-soft tissue impaction | \$245 |
| 9440 | Exam, problem focused, after hours | \$140 | | | | 7230 | Extraction-partial bony impaction | \$308 |
| | | | | | | 7240 | Extraction-comp bony impaction | \$375 |
| Preventive | | | | | | | | |
| 0210 | Full mouth x-ray, intraoral | \$50 | 4210 | Gingivectomy/Gingivoplasty 4+ teeth per quadrant | \$500 | | Other | |
| 0220-30 | Single x-ray, intraoral, periapical | \$12 | 4211 | Gingivectomy/Gingivoplasty 1-3 teeth per quadrant | \$203 | 9630 | Peridex irrigation | \$35 |
| 0270 | Bitewing x-ray 1 film | \$12 | 4341 | Scaling/root planing, 4+ teeth per quad | \$196 | Limitations/Exclusions | | |
| 0272 | Bitewing x-ray 2 films | \$36 | 4342 | Scaling/root planing, 1-3 teeth per quad | \$152 | 1. | Treatment that began prior to the Member's enrollment in the Del Valle Plan. | |
| 0274 | Bitewing x-ray 4 films | \$48 | 4355 | Full mouth debridement to enable evaluation and diagnosis | \$152 | 2. | Prophylaxis is limited to once every 6 months under code 1110. | |
| 0330 | Panoramic x-ray | \$50 | 4910 | Periodontal maintenance, per visit | \$125 | 3. | Denture relines are limited to two in any year. | |
| 0350 | Oral/facial images | \$15 | | | | 4. | Oral surgery requiring the setting of fractures or dislocations. | |
| 0460 | Pulp vitality test - 1 or more teeth | \$44 | | | | 5. | Myofunctional therapy, except as provided herein. | |
| 0470 | Diagnostic models | \$83 | | | | 6. | Prescription and over-the-counter medications are not covered benefits. | |
| 1110 | Prophylaxis (cleaning) adult | \$75 | | | | 7. | Treatment of malignancies, cysts, neoplasm, or congenital malformations. | |
| 1120 | Prophylaxis (cleaning) child | \$55 | | | | 8. | Hospital care needed in conjunction with dental treatment. | |
| 1203-04 | Fluoride treatment, topical | \$31 | | | | 9. | Loss or theft of any dental appliance. | |
| 1351 | Sealant - per tooth | \$25 | | | | 10. | Services that cannot be performed due to the general health of the member. | |
| 1510 | Space maintainer - fixed unilateral | \$185 | | | | 11. | Any procedure, therapy, and/or appliance used to increase vertical dimension or to restore the occlusion and/or treat conditions of the TMJ (temporomandibular joint). | |
| 1515 | Space maintainer - fixed bilateral | \$280 | | | | 12. | Dental care covered by Worker's Compensation, Employer Liability Laws, or no cost services provided by any governmental agency cannot be combined with The Del Valle Plan. | |
| 1550 | Recent space maintainer | \$33 | | | | 13. | An insufficient automatic bank withdrawal will automatically cancel your coverage. | |
| | | | | | | 14. | Implants and all related services are not a covered benefit. | |
| | | | | | | 15. | Any cosmetic related services are not a covered benefit. | |
| Restorative (fillings) | | | | | | | | |
| 2140 | Amalgam-1 surface, prim or perm | \$125 | | | | | | |
| 2150 | Amalgam-2 surface, prim or perm | \$165 | | | | | | |
| 2160 | Amalgam-3 surface, prim or perm | \$210 | | | | | | |
| 2161 | Amalgam-4 surface or more, prim or perm | \$252 | | | | | | |
| 2330 | Resin-1 surface-anterior | \$127 | | | | | | |
| 2331 | Resin-2 surface-anterior | \$155 | | | | | | |
| 2332 | Resin-3 surface-anterior | \$188 | | | | | | |
| 2335 | Resin-4 or more surface-anterior | \$236 | | | | | | |
| 2391 | Resin-1 surface-posterior | \$135 | | | | | | |
| 2392 | Resin-2 surface-posterior | \$174 | | | | | | |
| 2393 | Resin-3 surface-posterior | \$220 | | | | | | |
| 2394 | Resin-4 or more surface-posterior | \$262 | | | | | | |
| Crown Restorations | | | | | | | | |
| 2740 | Crown-porcelain/ceramic substrate | \$880 | | | | | | |
| 2752 | Crown-porcelain fused to noble metal | \$780 | | | | | | |
| 2790 | Crown-full cast high noble metal (full gold crown) | \$847 | | | | | | |
| 2920 | Recementation of crown | \$85 | | | | | | |
| 2930 | Crown-prefab stainless steel, prim tooth | \$216 | | | | | | |
| 2950 | Core build up/including pins, per tooth | \$220 | | | | | | |
| 2954 | Prefab/post/core in addition to crown | \$263 | | | | | | |



THE DEL VALLE PLAN

| Code | Description | Fee | Code | Description | Fee | Code | Description | Fee |
|-------------------------------|--|-------|------|---|-------|-------------------------------|--|-------|
| Diagnostic | | | | | | | | |
| 0120 | Exam, periodic | \$24 | 3220 | Therapeutic pulpotomy | \$76 | 7111 | Extraction-coronal remnants, prim | \$124 |
| 0140 | Exam, problem focused | \$33 | 3221 | Pulp debridement/not done as part of RCT | \$80 | 7140 | Extraction-erupted tooth | \$140 |
| 0150 | Exam, comp, new or established patient | \$25 | 3310 | Root canal therapy-anterior | \$556 | 7210 | Extraction-erupted tooth surgical | \$212 |
| 0180 | Exam, periodontal, including charting | \$50 | 3320 | Root canal therapy-bicuspid | \$648 | 7220 | Extraction-soft tissue impaction | \$245 |
| 9440 | Exam, problem focused, after hours | \$140 | | | | 7230 | Extraction-partial bony impaction | \$308 |
| | | | | | | 7240 | Extraction-comp bony impaction | \$375 |
| Preventive | | | | | | | | |
| 0210 | Full mouth x-ray, intraoral | \$50 | 4210 | Gingivectomy/Gingivoplasty 4+ teeth per quadrant | \$500 | | Other | |
| 0220-30 | Single x-ray, intraoral, periapical | \$12 | 4211 | Gingivectomy/Gingivoplasty 1-3 teeth per quadrant | \$203 | 9630 | Peridex irrigation | \$35 |
| 0270 | Bitewing x-ray 1 film | \$12 | 4341 | Scaling/root planing, 4+ teeth per quad | \$196 | Limitations/Exclusions | | |
| 0272 | Bitewing x-ray 2 films | \$36 | 4342 | Scaling/root planing, 1-3 teeth per quad | \$152 | 1. | Treatment that began prior to the Member's enrollment in the Del Valle Plan. | |
| 0274 | Bitewing x-ray 4 films | \$48 | 4355 | Full mouth debridement to enable evaluation and diagnosis | \$152 | 2. | Prophylaxis is limited to once every 6 months under code 1110. | |
| 0330 | Panoramic x-ray | \$50 | 4910 | Periodontal maintenance, per visit | \$125 | 3. | Denture relines are limited to two in any year. | |
| 0350 | Oral/facial images | \$15 | | | | 4. | Oral surgery requiring the setting of fractures or dislocations. | |
| 0460 | Pulp vitality test - 1 or more teeth | \$44 | | | | 5. | Myofunctional therapy, except as provided herein. | |
| 0470 | Diagnostic models | \$83 | | | | 6. | Prescription and over-the-counter medications are not covered benefits. | |
| 1110 | Prophylaxis (cleaning) adult | \$75 | | | | 7. | Treatment of malignancies, cysts, neoplasm, or congenital malformations. | |
| 1120 | Prophylaxis (cleaning) child | \$55 | | | | 8. | Hospital care needed in conjunction with dental treatment. | |
| 1203-04 | Fluoride treatment, topical | \$31 | | | | 9. | Loss or theft of any dental appliance. | |
| 1351 | Sealant - per tooth | \$25 | | | | 10. | Services that cannot be performed due to the general health of the member. | |
| 1510 | Space maintainer - fixed unilateral | \$185 | | | | 11. | Any procedure, therapy, and/or appliance used to increase vertical dimension or to restore the occlusion and/or treat conditions of the TMJ (temporomandibular joint). | |
| 1515 | Space maintainer - fixed bilateral | \$280 | | | | 12. | Dental care covered by Worker's Compensation, Employer Liability Laws, or no cost services provided by any governmental agency cannot be combined with The Del Valle Plan. | |
| 1550 | Recent space maintainer | \$33 | | | | 13. | An insufficient automatic bank withdrawal will automatically cancel your coverage. | |
| | | | | | | 14. | Implants and all related services are not a covered benefit. | |
| | | | | | | 15. | Any cosmetic related services are not a covered benefit. | |
| Restorative (fillings) | | | | | | | | |
| 2140 | Amalgam-1 surface, prim or perm | \$125 | | | | | | |
| 2150 | Amalgam-2 surface, prim or perm | \$165 | | | | | | |
| 2160 | Amalgam-3 surface, prim or perm | \$210 | | | | | | |
| 2161 | Amalgam-4 surface or more, prim or perm | \$252 | | | | | | |
| 2330 | Resin-1 surface-anterior | \$127 | | | | | | |
| 2331 | Resin-2 surface-anterior | \$155 | | | | | | |
| 2332 | Resin-3 surface-anterior | \$188 | | | | | | |
| 2335 | Resin-4 or more surface-anterior | \$236 | | | | | | |
| 2391 | Resin-1 surface-posterior | \$135 | | | | | | |
| 2392 | Resin-2 surface-posterior | \$174 | | | | | | |
| 2393 | Resin-3 surface-posterior | \$220 | | | | | | |
| 2394 | Resin-4 or more surface-posterior | \$262 | | | | | | |
| Crown Restorations | | | | | | | | |
| 2740 | Crown-porcelain/ceramic substrate | \$880 | | | | | | |
| 2752 | Crown-porcelain fused to noble metal | \$780 | | | | | | |
| 2790 | Crown-full cast high noble metal (full gold crown) | \$847 | | | | | | |
| 2920 | Recementation of crown | \$85 | | | | | | |
| 2930 | Crown-prefab stainless steel, prim tooth | \$216 | | | | | | |
| 2950 | Core build up/including pins, per tooth | \$220 | | | | | | |
| 2954 | Prefab/post/core in addition to crown | \$263 | | | | | | |

